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PEARLS *in Evaluating Patient Capacity to Make Medical Decisions*

ABSTRACT

Evaluations of patients' capacity to make medical decisions are among the most common and most complex consultations that psychiatrists are asked to perform. We describe tips that we have found to be helpful while performing capacity evaluations. We also share tips that should help the clinician make up his or her mind regarding the patient following capacity evaluations.



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INTRODUCTION

Evaluations of patients' capacity to make medical decisions are among the most common and most complex consultations that psychiatrists are asked to perform. In this article, we describe some tips that we have found to be helpful while performing patient capacity evaluations. Our own "field tests" on our residents and medical students indicate that these tips are very helpful to trainees. We also describe tips that may help the healthcare professional make up his or her mind regarding the patient's decision-making capacity.

For a discussion of the nature and standards of decision-making capacity, the reader is referred to classic articles on the subject.^{1,2} The pearls that follow focus instead on the "how to" of the assessment.

DOING THE CAPACITY EVALUATION

Pearl 1—Do the "consultation" but don't forget to "liaison."

Nonpsychiatric physicians have little understanding of capacity evaluations. Discussing this process with them can greatly facilitate performing evaluations. Similarly, even after careful review of the chart, the consulting psychiatrist may have a limited understanding of the patient's clinical condition, his treatment options, or the likely outcome of the treatment. Five minutes on the phone with the treating physician is often more helpful than 30 minutes reviewing the chart. Even more than in other psychiatric consults, it is absolutely essential to speak to the treating physician before doing the capacity evaluation and, in many cases, again after doing the evaluation.

Pearl 2—Capacity to do what?

The consult request

usually simply states, "Competency evaluation." Clarify with the primary team whether the evaluation is for the patient's capacity to refuse a particular treatment or to refuse a safe placement, etc., since the primary team usually does not understand that these are somewhat different evaluations. Decision-making capacity is neither "global" nor "durable." It is task-specific and may have a short or variable "shelf life."

Pearl 3—Do you know what the patient is supposed to know? When you receive the consultation request, the first thing to do is to call one of the physicians on the team that requested it and ask him or her to explain to you the information that you are going to elicit from the patient. If you don't know exactly what the potential benefits or risks of a procedure in the context of the particular care are, how can you test the patient on them?

Pearl 4—Has the patient been told? One of the common problems in performing capacity evaluations is that the treatment team has not told the patient in clear and simple terms the information that you are going to try to elicit from the patient. Therefore, when you first call the physician requesting the consult, ask what the patient has been told. If, as is often the case, it is not certain that the patient has been clearly educated regarding the choices, have a low threshold for requesting that the physician discuss the information again with the patient before you perform the capacity evaluation. If possible, be present while a member of the primary treatment team explains the medical information to the patient. Not only can you then have a better understanding of what the patient has been told and whether it was presented clearly

- **Decision-making capacity is neither "global" nor "durable." It is task-specific and may have a short or variable "shelf life."**
- **It is not the consultant's job to convince, educate, or persuade the patient...The consultant's job is just to determine if the patient has the capacity to decide.**
- **If you consistently have no problem reaching decisions regarding patient capacity evaluations, it is likely that you have become flippant regarding them.**

to the patient, but you are also privy first hand to the patient's attitude toward the explanations and any questions the patient had, which can be very helpful while performing in the capacity evaluation.

Pearl 5—"Death" is not enough as a description of the risks. A common finding is that when a patient is asked what his or her understanding of the risks of the procedure is (or of refusing it), he or she says, "I could even die." However, in many cases, they are only naming the most serious potential consequence of any choice, without specific knowledge of the risks to themselves. When they are pressed on other lesser risks or what might lead to their death, it becomes apparent that they do not actually understand the nature of the risks.

Pearl 6—A capacity evaluation was requested, but the patient is now agreeing with the treatment team's recommendation. This situation is not uncommon. However, if the patient's capacity to give valid consent has been called into question, it is important to determine the capacity not only to refuse the intervention, but also to agree to it. Also, such patients may change their minds again in a few hours.

Pearl 7—You are not your brother's keeper. It is not the consultant's job to convince or to educate the patient regarding the nature, risks, and benefits of the treatment, nor is it to persuade the patient to agree to the recommended intervention. The consultant's job is just to determine if the patient has the capacity to decide.

Pearl 8—It is often a process issue. As in many other clinical encounters, the process is often more revealing than the content regarding what

is going on. It is quite common to find that the "real" issue is a communication gap between the patient and the treatment team. Helping to resolve this gap may be more useful to the team than a capacity evaluation. There can be several different reasons for this communication problem, but often the issue is one of interpersonal conflict between the patient and the clinicians. Sensitivity and skill is needed in dealing with this situation. Often, guiding the treatment team in how to approach the patient is helpful. For example, one may discuss with the treatment team how Mr. Jones needs to be in control by having maximal opportunities to make decisions regarding his care in the hospital. On the other hand, the problem may lie more with a particular member of the treatment team (nurse or physician). These latter situations are also very difficult, and often it may be more expedient to attempt to minimize the patient's contact with that person.

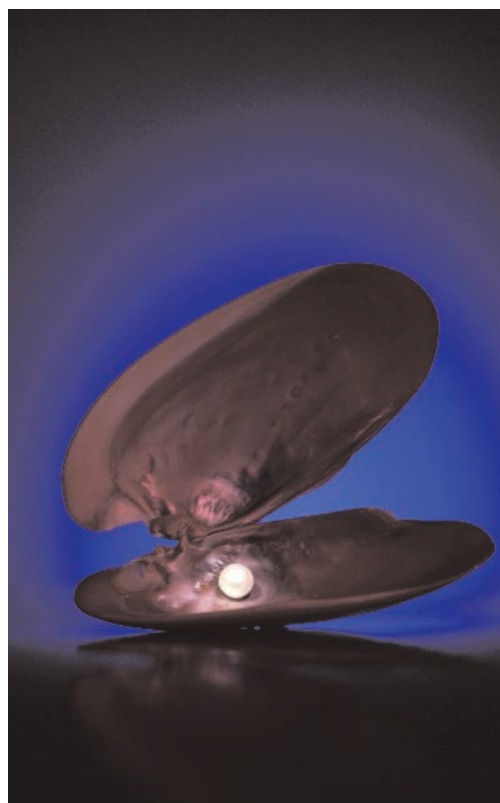
MAKING UP YOUR MIND

Pearl 9—To worry or not to worry?

Capacity evaluations are inherently difficult and have the potential for subjective error. Thus, if you find yourself consistently having no problem reaching decisions following patient capacity evaluations, it is likely that you have become flippant regarding them. If you are more aware of the complexities of the evaluation and decision making, often you will find yourself going back and forth in your mind, taking some antacid, sometimes going back to see the patient again, and

sometimes running your ideas by a colleague. Thus, the paradox is that if you are not worrying, you should!

Pearl 10—Capacity is the ability to give informed consent or informed refusal. Decisions regarding capacity are sometimes made more easily if you ask yourself, "Is this patient able to provide an informed consent (or refusal) of this treatment decision?" Essentially, that is what capacity consists of, and thinking in terms of



informed consent is easier for most clinicians.

Pearl 11—Capacity is like pudding! Often when the attending psychiatrist gives an opinion about capacity, the trainee will say, "But it may be because the patient is sedated, angry, or uncooperative." Although it is important to assess these factors in the patient's status and, in particular, to see if any of them can be ameliorated so as to

restore the patient's capacity, it is the end result that counts. Does the patient, at the time that a critical decision must be taken, demonstrate the capacity to make this decision? The proof of the pudding is in the tasting.*

Pearl 12—The flip side of the pudding. Even if the patient is psychotic, depressed, or has cognitive impairment, he may have sufficient capacity to make the medical decision, providing of course that he otherwise meets the tests of sufficient capacity.

Pearl 13—How high does the patient need to jump? Different thresholds of capacity

decision regarding whether the patient has sufficient capacity much easier.

Pearl 14—The “sleep test” for difficult decisions. When struggling to decide whether a patient has the capacity to refuse the recommended treatment, ask yourself, “Can I go home and sleep well without constantly worrying if the patient is OK?”

Pearl 15—The issue is not whether the treatment is appropriate or not. Sometimes clinicians are reluctant to say that the patient lacks capacity to agree to a medical intervention when they believe that the

decision that seems to be quite inappropriate. Remember that there is no requirement that a person with sufficient capacity must make what others think are the right decisions. They are free to make decisions that may be harmful for them. That is implicit in being free to decide.

CONCLUSION

While capacity evaluations will remain a sophisticated skill and a complex clinical challenge, application of these pearls may assist even experienced psychiatrists in making these determinations.

Take the Sleep Test—

When struggling to decide whether a patient has the capacity to refuse the recommended treatment, ask yourself, “Can I go home and sleep well with this decision without constantly worrying if this patient is OK?”

are needed for different decisions depending on the risk-benefit ratio of the proposed intervention. The greater the risk-benefit ratio, the higher the threshold for determining that the patient has sufficient capacity to make that decision. While doing the evaluation, it is helpful to keep in mind whether the patient needs to be held to a high or low standard for capacity. Thus, for example, if a decision has a significant risk of fatality, we know in advance that the patient must demonstrate a considerably high level of understanding of the decision. Keeping this in mind makes the

treatment is highly desirable, e.g., coronary angiography in a patient with recurrent substernal chest pain. However, the question is not “Should the patient should get this treatment?” but “Who should decide?” If the patient is found to lack the capacity to decide regarding the recommended intervention, the appropriate surrogate can make the appropriate decision for the patient.

Pearl 16—Free to be unwise. Clinicians may consider patients to lack the capacity to make the medical decision because the patient is making a

REFERENCES

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2. Roth LH, Meisel A, Lidz CW. Tests of competency to consent to treatment. *Am J Psychiatry* 1977;134(3):279-84.

* Some may not know that this commonly used phrase is a quote from Miguel de Cervantes's *The Adventures of Don Quixote*. ●